Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARK DICKIE
PO BOX 121589
ARLINGTON TX 76012

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0425-01

MFDR Date Received

October 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Mark Dickie requests Medical Dispute Resolution in pursuant of Rule 133.305 Medical Dispute Resolution in the above referenced patients case.

Per Rule 126.7 Designated Doctor Examinations: Request and General Procedures

This request was made in the form and manner prescribed by the Division. The report of the designated doctor is given presumptive weight regarding the issue(s) in question and/or dispute. The designated examination was requested to resolve question(s) about the following:

Impairment caused by the employee's compensable injury Attainment of maximum medical improvement."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No carrier's response received

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2012	CPT Code 99456-W5-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services

on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 22, 2012

   - W1 – Workers' compensation jurisdictional fee schedule adjustment

   Explanation of benefits dated May 24, 2012

   - 18 – Duplicate claim/service. This charge effective 1/1/2013: Exact duplicate claim/service

   Explanation of benefits dated June 12, 2012

   - 18 – Duplicate claim/service. This charge effective 1/1/2013: Exact duplicate claim/service

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-W5-WP in the amount of $500.00 with one unit for a Maximum Medical Improvement (MMI) and Impairment Rating (IR) examination.

   Per Administrative Code §134.204 states:

   (i) The following shall apply to Designated Doctor Examinations

   (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows

   (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include

   (3) The following applies for billing and reimbursement of an MMI evaluation

   (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350

   (4) The following applies for billing and reimbursement of an IR evaluation

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas

   (i) Musculoskeletal body areas are defined as follows

   (I) spine and pelvis;

   (II) upper extremities and hands; and,

   (III) lower extremities (including feet).

   (ii) The MAR for musculoskeletal body areas shall be as follows

   (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

   CPT Code 99456-W5-WP is supported. Review of submitted documentation EES-14, DWC-32 and DWC-69 support that a request for Designated Doctor Examination was requested to address Maximum Medical Improvement (MMI) and Impairment Rating (IR) examination with one body area being rated using Diagnosis Related Estimate (DRE).

   The total MAR for CPT Code 99456-W5-WP is $500.00.

2. The respondent issued payment in the amount of $350.00. Based upon the documentation submitted, additional reimbursement in the amount of $150.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/18/13 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.